COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

MENTAL HEALTH/SUBSTANCE ABUSE/DOMESTIC VIOLENCE/FAMILY PRESERVATION PROGRAM SERVICE PROVIDER PROGRESS REPORT

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[ ]

Reply To:

Attention: _____

OUR RECORDS INDICATE THAT THE FOLLOWING PARTICIPANT IS RECEIVING SERVICES IN YOUR PROGRAM. VERIFICATION OF PROGRESS IS NEEDED FOR HIS/HER CONTINUING ELIGIBILITY TO CalWORKs. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ABOVE ADDRESS WITHIN FIVE (5) CALENDAR DAYS FROM THE POST DATE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GAIN SERVICES WORKER AT THE PHONE NUMBER POSTED IN SECTION A BELOW.

A - Completed by GAIN SERVICES WORKER (GSW)/CONTRACTED CASE MANAGER (CCM)/REFUGEE EMPLOYMENT PROGRAM CASE MANAGER (RCM)

Participant:		Case No.:		
Social Security No.:		Date of Birth:	Exempt Volunteer Status:	
GSW/CCM/RCM:	File No.:	Telephone No.: ( )	Fax No.: ( )	Date:

B - Completed by Service Provider (Complete and return to the GSW/CCM/RCM within five (5) calendar days from the post date)

I. TYPE OF SERVICE

☐ Mental Health ☐ Substance Abuse ☐ Family Preservation

☐ Domestic Violence (DV) Case Management ☐ Domestic Violence (DV) Legal Services

II. DUAL DIAGNOSIS/CONCURRENT SERVICES (if applicable)

☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services

III. PROGRESS (Complete as applicable) The above-referenced CalWORKs participant:

1. ☐ is participating and maintaining progress consistent with the above Specialized Supportive Services/Family Preservation activity for _____ hrs/week and _____ days/week.
2. ☐ is enrolled in Life Skills Support Group. Start Date _____/ _____ /_____ Completion Date_____/_____/_____.
3. ☐ is no longer receiving treatment/services effective _____/ _____ /_____ for:
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services ☐ Family Preservation
4. ☐ is expected to complete treatment/services on _____/ _____ /_____ (if less than 90 days).
   ☐ Mental Health ☐ Substance Abuse ☐ DV Case Management ☐ DV Legal Services ☐ Family Preservation
5. ☐ has dropped-out of treatment/services effective _____/ _____ /_____ .
6. ☐ has completed treatment/services on _____/ _____ /_____ .
7. ☐ is recommended for an extension of the Specialized Supportive Services/Family Preservation activity until _____/_____ /_____ (more than 90 days).

VI. **CONCURRENT ACTIVITY** **Evaluate participant's ability to participate in a concurrent activity every three (3) months from start date of services. (Does not apply to Family Preservation Agency)** The above referenced CalWORKs participant:

☐ **(DV only)** is able to participate in another WtW activity: _____ for hours/week_____ , days/week _____.
☐ outside of a WtW Plan ☐ within a WtW plan

☐ is able to participate in another WtW activity: _____ for hours/week _____, days/week _____.
☐ within the WtW plan ☐ as an exempt volunteer ☐ within Post Time Limit Services

If the participant is not able to participate for a total of 32/35 hrs/week in WtW activities, the participant may be eligible for a medical exemption via the CW 61 and receive services as an Exempt Volunteer.

Service Provider/Staff Person's Name:	Title:	Phone No.:	Date: